STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

MONTHLY CLAIM FOR DRUG/MEDI-CAL REIMBURSEMENT

AND

MONTHLY PROVIDER SERVICE AND REVENUE SUMMARY

Submission Type (check one):

- [ ] ORIGINAL
- [ ] SUPPLEMENTAL
- [ ] CalWORKS (Substance Abuse Trtmt./Work Plan)

Check one

- COUNTY [ ]
- DIRECT CONT. [ ]

DATE

PAGE OF

COUNTY	COUNTY CODE	CLAIM FOR MO/YR /	CONTRACT #	PROGRAM CODE (check one) [ ] 20 (Alc/Drug) [ ] 25 (Perinatal)	FISCAL YEAR /

BATCH # State Use Only	PROVIDER NAME	PROV. #	SFC	UNITS OF SERVICE	$ AMOUNT CLAIMED BY EACH PROVIDER	$ ADJUSTMENTS TO GROSS CLAIM REVENUE BY SOURCE PATIENT INS.	SHARE OF COST	PATIENT FEES	OTHER	ADJUSTMENTS ADP SITE VISIT	CLAIM ADJUST.	TOTAL $/CENTS R REVENUE AND/OR JUSTMENTS	NET CLAIM $/CENTS
	PAGE TOTALS				$							$	$
	GRAND TOTALS				$							$	$

SIGNATURE OF COUNTY/CONTRACTOR FISCAL REPRESENTATIVE | DATE | ( ) PHONE

COUNTY CERTIFICATION

I CERTIFY the services listed on this form have been personally provided to the patient by the provider or under his direction by another person eligible under the Medi-Cal Program to provide such services and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from Federal and/or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and/or State laws. The provider agrees to keep for a minimum period of three years from the date of service all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any information regarding payments claimed for providing the services, ce; Medi-Cal Audits Project, Office of State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives.

Medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SIGNATURE: _____ **DATE:**_____ **EXECUTED AT:**_____**, CA**

ALCOHOL/DRUG PROGRAM ADMINISTRATOR

DIRECT CONTRACTOR CERTIFICATION

I CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Program services in and for said claimant; that I have not violated any of the provisions of Sections 1090 through 1096 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct and in accordance with the law.

SIGNATURE_____ **DATE:**_____**EXECUTED AT:**_____**,CA.**

CONTRACT ADMINISTRATOR

COUNTY/DIRECT CONTRACTOR

I CERTIFY under penalty of perjury that I am the duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts.

SIGNATURE:_____ **DATE:**_____ **EXECUTED AT:**_____**, CA**

TITLE:_____ **(EXAMPLE: COUNTY /CONTRACTOR AUDITOR-CONTROLLER, FINANCE OFFICER, ETC.)**

'*** NOTE ! ! SIGNATURES ARE REQUIRED ONLY ON THE GRAND TOTAL PAGE *****

Completion instructions for ADP 1592

Revised 3/98

THIS FORM SHOULD BE USED FOR BOTH THE COUNTY AND THE DIRECT CONTRACT PROVIDERS

I. GENERAL

The ADP 1592 - MONTHLY CLAIM FOR DRUG/MEDI-CAL REIMBURSEMENT AND MONTHLY PROVIDER SERVICE AND REVENUE SUMMARY is used for reporting total Drug/Medi-Cal units of service, total dollar amount claimed, total revenue collected/reported by source, claim adjustments and the net claim amount by provider.

II. HEADING INSTRUCTIONS

a. Type of Submission - check the type of claim being submitted
b. Check the type of claim being submitted either by the County or the Direct Contract Provider.
c. County - enter name of county submitting claim
d. County Code - enter the two digit county code
e. Contract # - enter the Direct Contract Provider Number (for DIRECT CONTRACT PROVIDERS ONLY).
f. Claim for Mo/Yr - enter month/year in which the claim is being submitted.
g. Program Code - check the appropriate box for Drug Services (20) or Perinatal Services (25)
h. Fiscal Year - enter fiscal year of service
i. Date - enter the date this form was completed
j. Page/of - enter each page number and total of pages (i.e., page 1 of 9)

III. COLUMNAR INSTRUCTIONS

a. Provider Name - enter name of program providing services. If Direct Contract Provider - enter the provider name.
b. Provider Number - enter the four digit provider number assigned by the Department of Alcohol and Drug Programs
c. Service Function Code (SFC) - enter the two digit SFC; 20-22= Methadone Dose, 23-25 =LAAM Dose, 26-27=NTP Individual Counseling, 28-29=NTP Group Counseling, 30-39=Daycare Habilitative, 40-49=Perinatal Residential, 50-59=Naltrexone, 80-84=Outpatient Drug Free Individual Counseling, 85-89=Outpatient Drug Free Group Counseling.
d. Units of Service - for each service function code, determine and enter the units of service rendered or reported by each provider for the claim month
e. Amount Claimed - for each service function code, determine the total dollars, including cents, incurred or reported by the provider for the claim month.
NOTE!! ALL INCURRED OR REPORTED DOLLARS BILLED MUST BE SUPPORTED BY THE ADP 1584 DRUG/MEDI-CAL ELIGIBILITY WORKSHEETS
f. Adjustments to the Gross Claim: REVENUE - for each service function code and each provider, determine and enter the total revenue collected or reported during the claim month by revenue source. REVENUE SOURCES NOT LISTED ON FRONT MAY BE REPORTED UNDER THE "OTHER" COLUMN AND $ AMOUNT ENTERED. The revenue not listed on front is: Grants,
Adjustments - enter adjustments by provider. (only deduct current FY adjustments)
g. Total Revenue Adjustments - enter total of both revenue and adjustments. (Should never show a negative $ amount).
h. Net Claim - net claim equals amount claimed, minus total revenue and/or adjustments.
i. Page Totals - enter column totals for units of service, amount claimed, total revenue and/or adjustments and net claim.
j. Grand Totals - on the last page of the monthly invoice, enter the grand totals of amount claimed, total revenue and/or adjustments and net claim.

IV. County Fiscal Representative or Direct Contact Provider Representative - the signature and phone number (including the area code) of the responsible county/contractor representative for contact purposes.

V. CERTIFICATION STATEMENTS - sign the appropriate certification statement.

a. COUNTY CERTIFICATION - the signature of the County Alcohol/Drug Program Administrator (FOR COUNTY ONLY)

b. DIRECT CONTRACT PROVIDER - the signature of the Contract Administrator (FOR DIRECT CONTRACT PROVIDERS ONLY).

VI. FISCAL OFFICER - signature of the County Auditor Controller or Finance Officer, or the Direct Contractor Finance Officer (FOR BOTH COUNTY AND DIRECT CONTRACT PROVIDERS).

NOTE: THREE ORIGINAL SIGNATURES ARE REQUIRED ON THE ADP 1592. SIGNATURES ARE REQUIRED ON ANY PAGE ON WHICH A GRAND TOTAL IS ENTERED.

VII. SUBMISSION INSTRUCTIONS:

1. The original Eligibility Worksheet (ADP 1584).
2. Original Adjustments by Provider form (ADP 5035 Rev.) with original signatures, and two copies (if adjustments are made to this month's claim).
3. Original Monthly Claim for Drug/Medi-Cal Reimbursement (ADP 1592) with original signatures and three (3) copies.

MAIL TO:

Department of Alcohol and Drug Programs
Drug/Medi-Cal Section
1700 "K" Street
Sacramento, CA 95814-4037

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